

CERTIFICATE OF DEATH

12285

12296

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Penna. b. COUNTY Chester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun Rural		c. LENGTH OF STAY IN 1b Months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert Manor Nursing Home		e. STREET ADDRESS R. F. D. # 1	
3. NAME OF DECEASED (Type or print) Alson Bappit Arnold		4. DATE OF DEATH Month Sept. Day 15 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-23-1880
9. AGE (In years st birthday) 87 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) Vermont		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Weston Arnold		14. MOTHER'S MAIDEN NAME Zerush Bappit	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 262-80-8639	
17. INFORMANT Mrs. Alson Arnold		Address Same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Septicemia (b) Nephritis DUE TO Cerebro-vascular Accident (c) Accident		INTERVAL BETWEEN ONSET AND DEATH 3 days 4 mos. 19 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 14, 1967 , to Sept 15, 1967 , that (I) (we) last saw the deceased alive on Sept 14, 1967 , and that death occurred at 3:30 PM , from causes and on the date stated above.			
22a. SIGNATURE Toy G. Davis		22b. DATE SIGNED SEP. 18, 1967	
22c. PHYSICIAN'S NAME (Type) Toy G. Davis M.D.		22d. ADDRESS Oxford Penna.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-18-1967	23c. NAME OF CEMETERY OR CREMATORY Friends Cem.	23d. LOCATION (City or Town) (County) (State) Calvert Cecil Md.
24. FUNERAL DIRECTOR Thomas E. McPherson		25a. REC'D BY REGISTRAR SEP 19 1967	
ADDRESS Rising Sun, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10075

Cell

Coaster

William M. Howard, Montana

Stephen

Hand

Oliver James, American

A. F. D. E. I.

Alison

Arnold

Sept.

12

Miss White

8-7-1840

87

Bar. Geo. Fair

Vermon

U.S.A.

Arrol

Barth

Barth

185-2-1840 Mr. Alfred Linnell, 3000 N. Ave.

U.S. District Court
Northern District of California
San Francisco, California

1900
H. J.
C. J.

Dep. J. Jones
Sept 4, 1897
2nd 14
2nd 14
2nd 14

Top. O. Davis, N.E.

1-10-1897 Western Co.

Barth, Geo. W.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12286

12297

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON Md.		c. LENGTH OF STAY IN 1b 2 Wks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KATHRYN P. Benson		4. DATE OF DEATH Month Sept. Day 19 Year 1967			
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 22, 1878	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) P.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILLIAM A. PYLE		14. MOTHER'S MAIDEN NAME MARY A. HANNUM	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT J. HOWARD PYLE Address CITY, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Chronic arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic (c) Arteriosclerotic					INTERVAL BETWEEN ONSET AND DEATH Several years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Death , 19 36 , to Sept 19 , 19 67 , that (I) (we) last saw the deceased alive on Sept 19 , 19 67 , and that death occurred at 2:45 PM , from causes and on the date stated above.					
22a. SIGNATURE Henry V. Dalls MD		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/19/67	
22c. PHYSICIAN'S NAME (Type) HENRY V. DALLS MD		22d. ADDRESS CHESAPEAKE CITY MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 9-23-67	23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION (City or town) (County) (State) CHESAPEAKE CITY Cecil Md.	
24. FUNERAL DIRECTOR PPPIV FUNERAL HOME		ADDRESS ELKTON MD		25a. REC'D BY REGISTRAR SEP 25 1967	
				25b. REGISTRAR'S SIGNATURE [Signature]	

IN SENATE,
January 10, 1901.
REPORT
OF THE
COMMISSIONER OF
THE
LANDS AND MINES,
FOR THE YEAR
1900.
TALLAHASSEE,
FLORIDA:
J. W. BARNES, PRINT-
ER.
1901.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12287

CERTIFICATE OF DEATH

12298

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON MD</u>		c. LENGTH OF STAY IN IS <u>INSF</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHESAPEAKE CITY</u>		d. STREET ADDRESS <u>071</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>UNION HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HENRY J. BORGER</u>		4. DATE OF DEATH Month <u>SEP</u> Day <u>11</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/2/97</u> AGE (In years last birthday) <u>70</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BOATING</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HARRY BORGER</u>		14. MOTHER'S MAIDEN NAME <u>ALETHA LOUIBERSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>109-12-4413</u>	
17. INFORMANT <u>HOSPITAL RECORDS</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY DISEASE</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CHRONIC ARTERIOSCLEROTIC HEART DISEASE</u> (c) <u>ALCOHOLIC</u> INTERVAL BETWEEN ONSET AND DEATH <u>SEVERAL YEARS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>CHRONIC ARTERIOSCLEROSIS</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> or work or work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 17</u> , 19 <u>67</u> , to <u>SEP 11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Sept 5</u> , 19 <u>67</u> , and that death occurred at <u>11:30</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Henry J. Danks MD</u>		22b. DATE SIGNED <u>9/11/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>HENRY J. DANKS MD</u>		22d. ADDRESS <u>CHESAPEAKE CITY MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9-14-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BETHEL CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>CHESAPEAKE CITY MD</u>	
24. FUNERAL DIRECTOR <u>PIPPIN FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>ELKTON, MD</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>SEP 13 1967</u>	

STATE OF TEXAS

188

IN SENATE, FEBRUARY 1, 1888.

REPORT OF THE
COMMISSIONER OF THE
LAND OFFICE
FOR THE YEAR
1887.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12288

CERTIFICATE OF DEATH

12299

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Aikin Ave.</u>				d. STREET ADDRESS <u>Aikin Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Kathryn</u> Middle <u>Geary</u> Last <u>Calvert</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>22</u> Year <u>19 67</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cau.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Aug. 4, 1886</u>		9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Geary</u>				14. MOTHER'S MAIDEN NAME <u>Amelia Greenlee</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Zebra Calvert, Perryville, Maryland.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>334X</u> IMMEDIATE CAUSE (a) <u>Cerebral Sclerosis</u> DUE TO (b) <u>Arterio Sclerosis</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u> </u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>November, 1962</u> to <u>Sept. 22, 1967</u> that (I) (we) last saw the deceased alive on <u>Sept 22 1967</u> , and that death occurred at <u>4:30 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Clarence I. Benson</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Sept. 23-67.</u>	
22c. PHYSICIAN'S NAME (Type) <u>Clarence I. Benson M.D.</u>				22d. ADDRESS <u>Port Deposit, Maryland.</u>			
23a. BURIAL, CREMATION, REMOVAL, etc. <u>Burial</u>		23b. DATE THEREOF <u>Sept 25, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grave Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Aberdeen, Maryland.</u>	
24. FUNERAL DIRECTOR <u>Lee A. Patterson & Son</u> ADDRESS <u>Perryville, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

John A. ...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...

...



...

...

...

...

...

...

...

...

FOR STATE
HEALTH DEPT

12289

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12300

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Northeast (elkton) c. LENGTH OF STAY IN Tb Northeast d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Northeast d. STREET ADDRESS 35 S. Main St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGARET Middle PEARL Last CLARK		4. DATE OF DEATH Month September Day 21 Year 19 67	
5. SEX Female	6. COLOR OR RACE Indian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 18, 1909
9. AGE (In years lost birthday) 58 yrs.		10. IF UNDER 1 YEAR Months 58 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY V.F.W.	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William C. Clark		14. MOTHER'S MAIDEN NAME Mary Wyatt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Virginia Hughey		Address Milton, Del.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED 9/22/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-25-67	23c. NAME OF CEMETERY OR CREMATORY North East Methodist	23d. LOCATION (City or Town) (County) (State) North East Cecil Md.
24. FUNERAL DIRECTOR Paul R. Cronch Grant Funeral Home		25a. REC'D BY REGISTRAR DATE SEP 26 1967	
25b. REGISTRAR'S SIGNATURE James J. Jones			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

5/12/06

542 *Journal of Management Inquiry* 16(5)

2024/05/28 14:12

1992

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

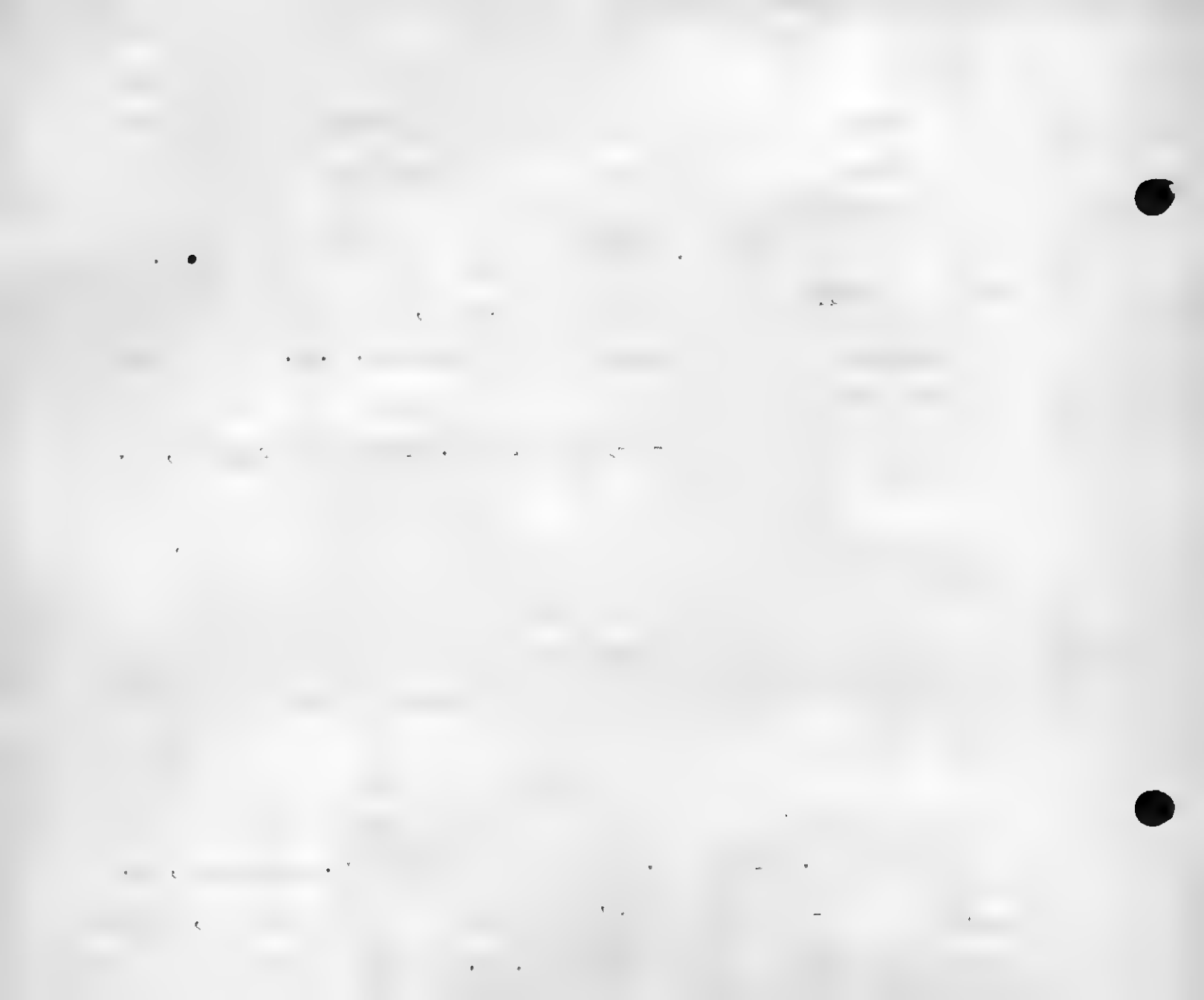
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12200

12301

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Charlestown	
c. LENGTH OF STAY IN 1b 13 days		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JEAN R. Middle CROUCH Last		4. DATE OF DEATH Month Sept. Day 7 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 21, 1919
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR (Months) Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Mercer Co. W.Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur Johnson		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 234-32-5701	
17. INFORMANT Frank R. Crouch		Address Charlestown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized metastatic carcinoma. DUE TO (b) Papillary carcinoma of the ovary DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from Sept. 5, 1966 , to Sept. 7, 1967 , that (2) (we) last saw the deceased alive on Sept. 6, 1967 , and that death occurred at 3 P.M. , from the causes and on the date stated above.			
22a. SIGNATURE Jay S. Barnhart Jr.		22b. DATE SIGNED Sept 8, 1967	
22c. PHYSICIAN'S NAME (Type) Jay S. Barnhart Jr.		22d. ADDRESS 4 Mauldin Ave., North East, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-10-67	
23c. NAME OF CEMETERY OR CREMATORY Hart's Cemetery		23d. LOCATION (City, town or county) (State) Cecil County, Maryland	
24. FUNERAL DIRECTOR Paul R. Crouch Grant Funeral Home		25a. REC'D BY REGISTRAR SEP 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

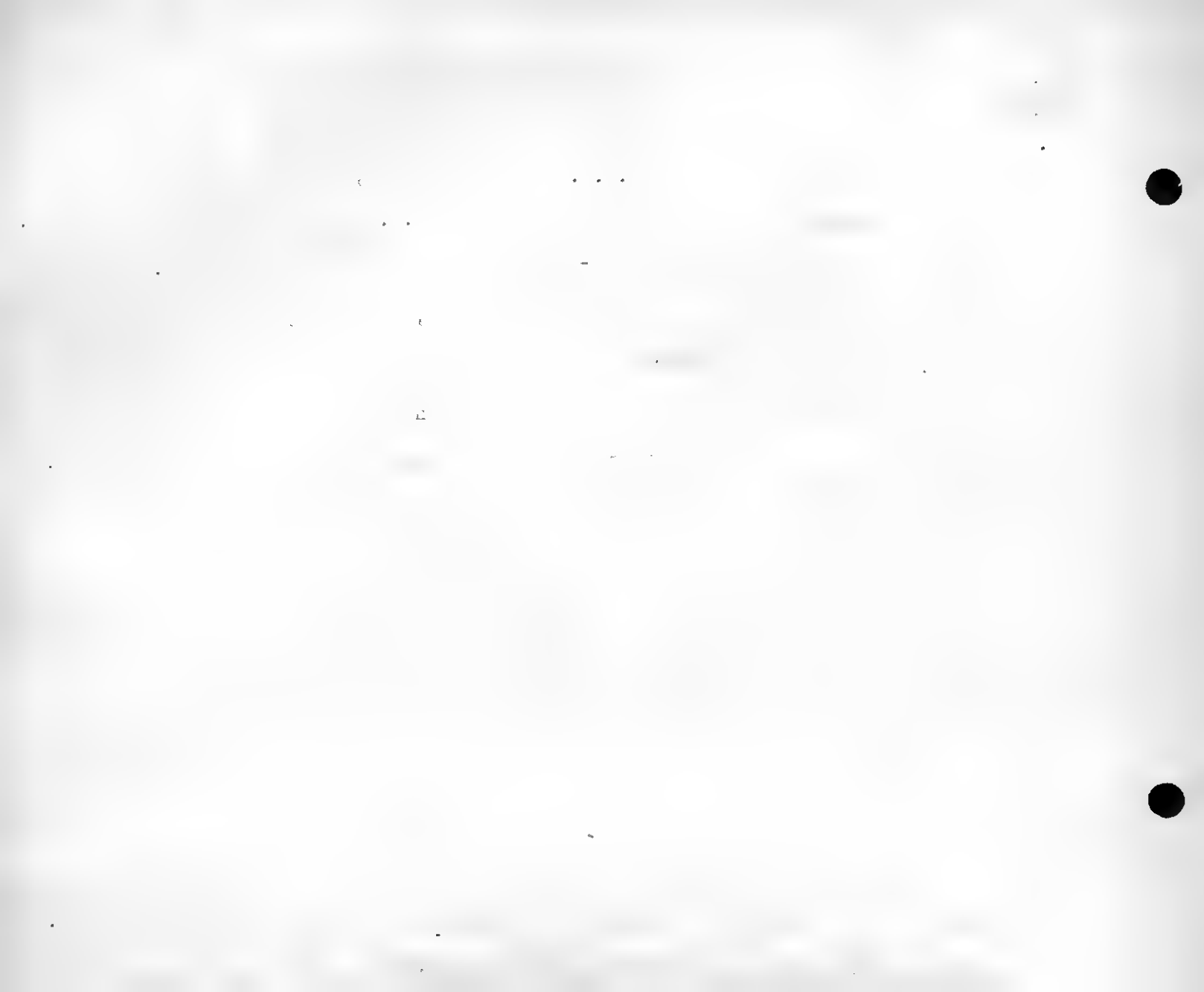
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12291

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12302

1 PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institutional Residence before admission) a. STATE Maryland b. COUNTY Cecil				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Elkton			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS R.D. 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) RILEY ALFRED DICKENS				4 DATE OF DEATH Month Sept. Day 30 Year 1967				
5. SEX Male		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Sept. 4, 1916		
9 AGE (In years last birthday) 51 yrs.		10 UNDER 1 YEAR Months 11 Days 4		11 UNDER 24 HRS Hours 14 Min. 00				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Timber Cutter			10b. KIND OF BUSINESS OR INDUSTRY Lumber		11 BIRTHPLACE (State or foreign country) South Dakota		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Emanuel Dickens				14. MOTHER'S MAIDEN NAME Sarah May				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 192-12-6858		17 INFORMANT Anna Pauline Dickens		Address Box 562 Elkton, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Electrocution 11/4. 8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Contact with R.R. high voltage transformer					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 6:30 p.m. 9-30-1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) R.R. power pole		20f. (City or town) (County) (State) Elkton Cecil Md.		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Tillman D. Johnson M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 9-30-67		
EXAMINER'S NAME (Type) Tillman D. Johnson M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town or county) 103 Singler Ave., Elkton		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-5-67		23c. NAME OF CEMETERY OR CREMATORY North East Methodist		23d. LOCATION (City or Town) (County) (State) North East Cecil Md.		
24. FUNERAL DIRECTOR Paul A. Rouch ADDRESS Box 22 North East, Md.				25a. REC'D BY REGISTRAR OCT 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		



CERTIFICATE OF DEATH

12303

12242

1 PLACE OF DEATH a. COUNTY Cecil MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Elkton		c. LENGTH OF STAY in ib Rural, Elkton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Iron Hill Road		d. STREET ADDRESS Iron Hill Road	
3 NAME OF DECEASED (Type or print) First Middle Last GEORGE A. ELY		4 DATE OF DEATH Month Day Year 9-7-67 19	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7-8-1898 69 yrs.
9 AGE (In years last birthday) 69		10 IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Agriculture	
11. BIRTHPLACE (County & State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Edwin S. Ely		14 MOTHER'S MAIDEN NAME Flora Fenn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16 SOCIAL SECURITY NO. 221-24-4314	
17. INFORMANT Margaret B. Ely		Address	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Massive intra-abdominal and right hypochondri DUE TO recurrence of clear cell carcinoma of the right Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) kidney. DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March , 19 66 , to Sept , 19 67 , that (I) (we) last saw the deceased alive on July 24 , 19 67 , and that death occurred at 4 A.M. , from causes on the date stated above.			
22a. SIGNATURE C. R. Donoho <i>C. R. Donoho</i> M.D.		22b. DATE SIGNED 9-8-67	
22c. PHYSICIAN'S NAME (Type) C. R. Donoho, M. D.		22d. ADDRESS Newark, Delaware	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-9-67	23c. NAME OF CEMETERY OR CREMATORY Lower Brandywine	23d. LOCATION (City or Town) (County) (State) Wilmington, Dela. N.C.
24. FUNERAL DIRECTOR William J. Narwick		25a. REC'D BY REGISTRAR DATE SEP 11 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12304

12293

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

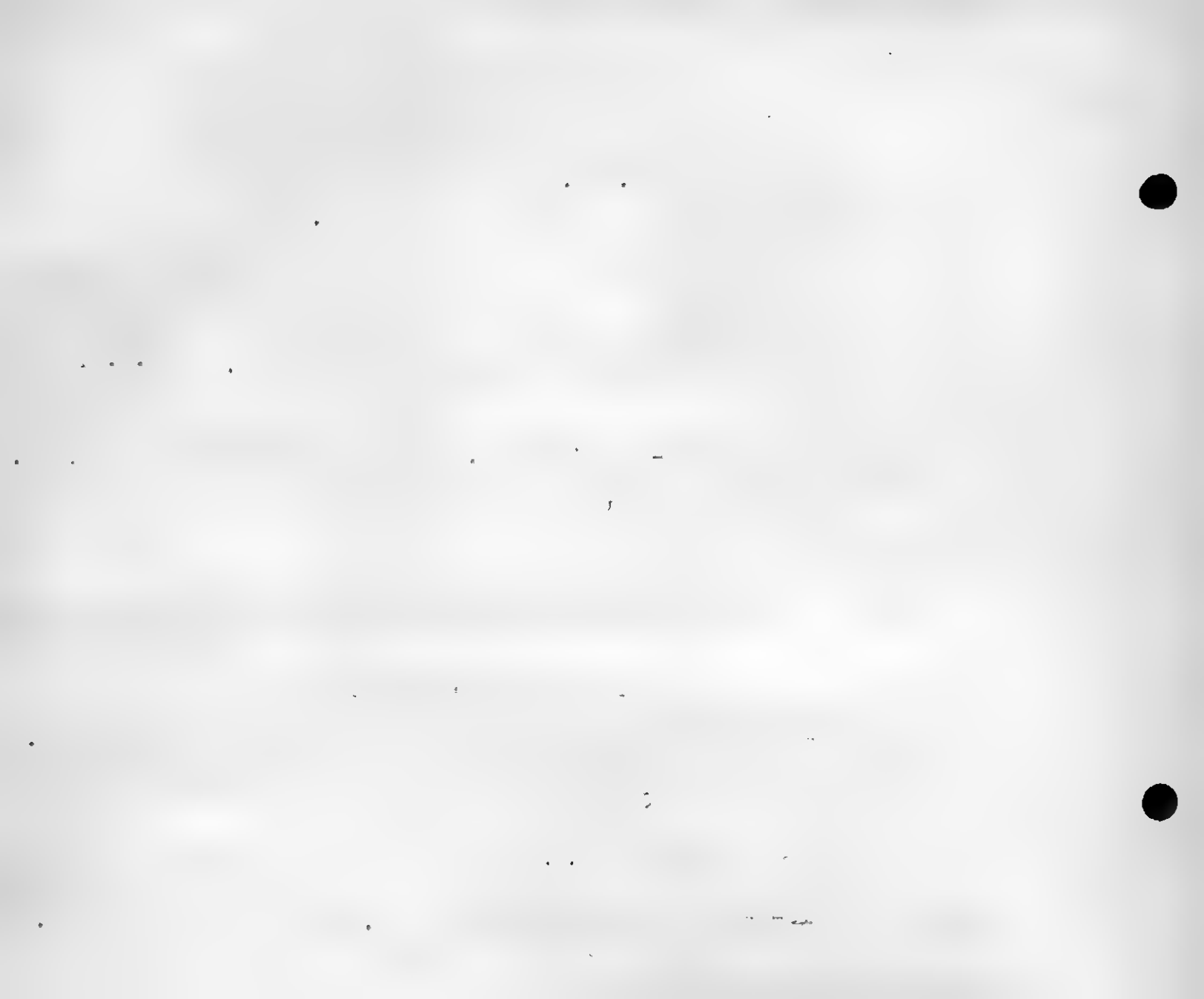
FOR STATE
HEALTH DEPT.

1 PLACE OF DEATH a. COUNTY CECIL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN b. D.O.A.		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY CECIL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun d. STREET ADDRESS Haines Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last JUNIOR BILLY FRAZIER		4 DATE OF DEATH Month Day Year September 29, 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 21, 1928
9 AGE (In years lost birthday) 39 yrs		10 UNDER 1 YEAR Months Days 07.1	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Relief Man Paint Shop Chrysler Motors Worth West Va.		10b KIND OF BUSINESS OR INDUSTRY U.S.A.	
11 BIRTHPLACE (State or foreign country) U.S.A.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Albert Frazier		14 MOTHER'S MAIDEN NAME Emma White	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 231-24-5494	
17 INFORMANT Mrs. Junior Frazier		Address Rising Sun, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple traumatic injuries 816.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (Partial)			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH Passenger in auto-auto collision	
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) highway (partial)		20c PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) CALVERT CECIL MD.	
20d TIME OF INJURY Month, Day, Year Hour a.m. 6:00 9-29-19 67		20e INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22. DATE SIGNED September 29, 1967		23a BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b DATE THEREOF 10-2-1967		23c NAME OF CEMETERY OR CREMATORY West Nottingham Cem. Colora Cecil Md.	
23d LOCATION (City or Town) (County) (State) Rising Sun, Md.		23e REC'D BY REGISTRAR OCT 3 1967	
23f REGISTRAR'S SIGNATURE Charles Judge		23g EXAMINER'S SIGNATURE Charles S. Springate, M.D.	
23h FUNERAL DIRECTOR Richard L. Goodie		23i ADDRESS Rising Sun, Md.	

TO DEPUTY MEDICAL EXAMINER:

necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



12294

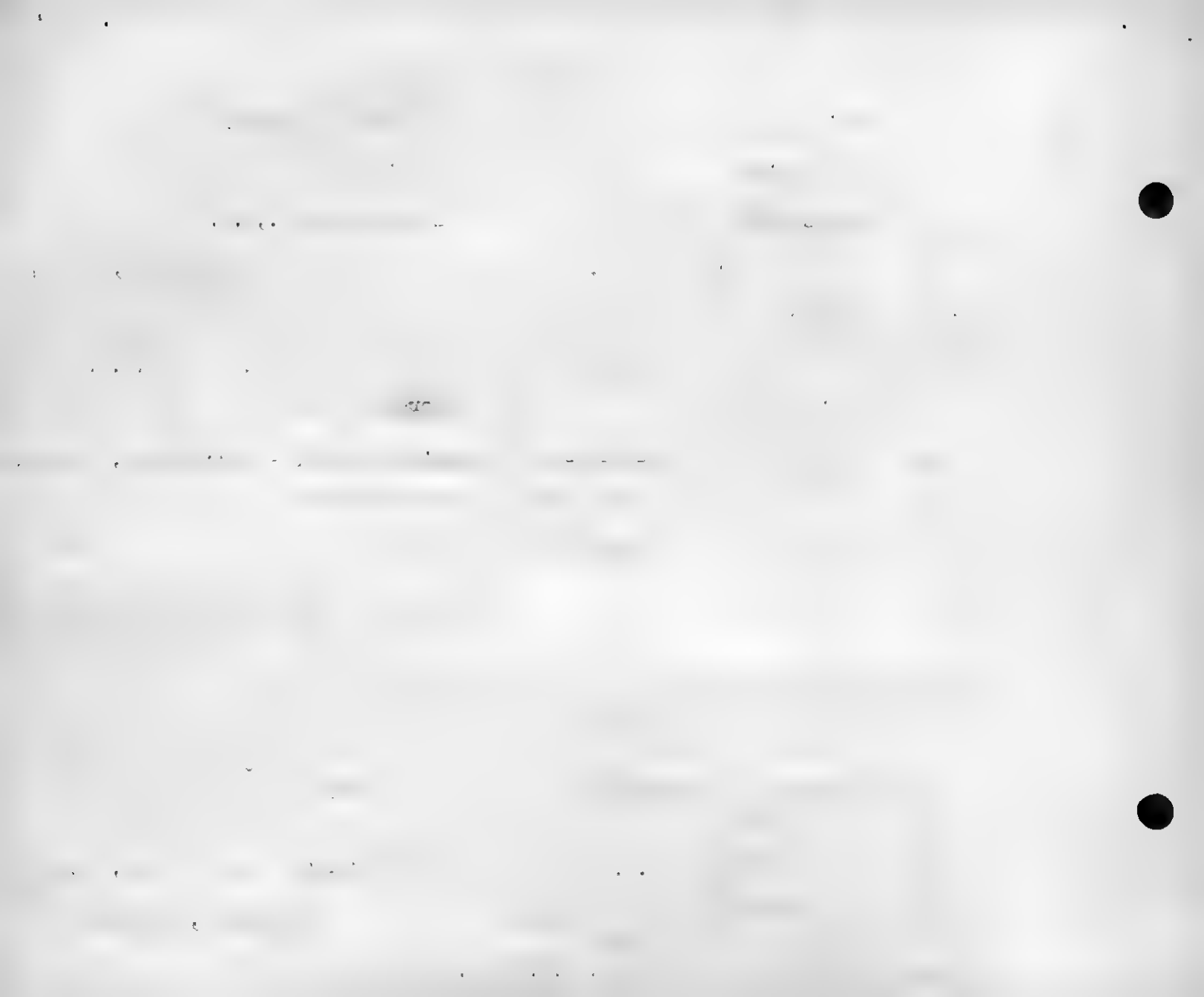
CERTIFICATE OF DEATH

12305

1 PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE DISTRICT OF COLUMBIA b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c LENGTH OF STAY IN 1b 11 days	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital		d. STREET ADDRESS 1658 Euclid St., N.W.	
3 NAME OF DECEASED (Type or print) Herman A. GIVENS		4 DATE OF DEATH Month September Day 3 Year 19 67	
5 SEX Male	6 COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8 23 10
9 AGE (In years lost birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY Labor	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander Givens		14. MOTHER'S MAIDEN NAME Florence Blackwell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. 231-32-25-64	
17. INFORMANT VA Hospital Records - Perry Point, Maryland		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, Aspiration Type DUE TO (b) Carcinoma of Pancreas with DUE TO (c) generalized carcinomatosis		INTERVAL BETWEEN ONSET AND DEATH 1-10 days At least 6 months	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour pm 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8 23 67 , 19 pm to 9 3 67 , 19 pm and that death occurred on 11-35 M, from causes on and on the date stated above.			
22a. SIGNATURE S. Goldgraben		22b. DATE SIGNED 9-4-67	
22c. PHYSICIAN'S NAME (Type) S. GOLDGRABEN, M.D.		22d. ADDRESS VA Hospital - Perry Point, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 9/8/1967	
23c. NAME OF CEMETERY OR CREMATORY Harmony		23d. LOCATION (City or Town) (County) (State) Landover, Maryland	
24. FUNERAL DIRECTOR Walton Simon		25a. REC'D BY REGISTRAR SEP 6 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
12395										
12306										
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, North East				c. LENGTH OF STAY IN 1b 5 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, North East				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D. 2					d. STREET ADDRESS R.D. 2			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Emma Powell Gray					4. DATE OF DEATH Sept. 14 1967		Month Day Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 27, 1879		9. AGE (In years last birthday) 88 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) New Castle Co. Del.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William R. Powell					14. MOTHER'S MAIDEN NAME Elizabeth Lofland					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 221-30-8096		17. INFORMANT Mrs. Linda Dolinger		Address R.D. 2 North East, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular insufficiency DUE TO (b) Senile and arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (1) (this hospital) attended the deceased from Aug. 1967, to Sept. 1967, that (1) (we) last saw the deceased alive on Sept 6 1967, and that death occurred at 11 AM, from the causes and on the date stated above.										
22a. SIGNATURE Jay S. Barnhart Jr.					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-14-67			
22c. PHYSICIAN'S NAME (Type) Jay S. Barnhart Jr.					22d. ADDRESS 4 Mauldin Ave., North East, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-16-67		23c. NAME OF CEMETERY OR CREMATORY Silverbrook		23d. LOCATION (City, town or county) (State) Wilmington Del.				
24. FUNERAL DIRECTOR Paul R. Crouch					ADDRESS Box 22 North East, Md.		25a. REC'D BY REGISTRAR SEP 18 1967		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
CERTIFICATE OF DEATH			
1 PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
c. LENGTH OF STAY (In days and months) 25 days 2 mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 1803 Pennsylvania Avenue	
3 NAME OF DECEASED (Type or print) JAMES GRIFFIN		4. DATE OF DEATH September 4 19 67	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 3-8-96
9 AGE (In years lost birthday) 71 yrs.		IF UNDER 1 YEAR: Months 4 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (County & State or foreign country) Camden, New Jersey		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14 MOTHER'S MAIDEN NAME Unknown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO 220-54-5903	
17 INFORMANT VA Hospital Records, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerosis, generalized			INTERVAL BETWEEN ONSET AND DEATH 4-7 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from June 18 19 38 to Sept. 4 19 67 , and that death occurred at 7:50 pm from causes and on the date stated above.			
22a SIGNATURE A. L. Mooney		22b DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D.		22d ADDRESS VAH, Perry Point, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) 9/11/67	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY Baltimore National	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Nutter Funeral Home, 3035 W. North Ave.,		25a. REC'D BY REGISTRAR SEP 15 1967 25b. REGISTRAR'S SIGNATURE	



12297

CERTIFICATE OF DEATH

12308

1 PLACE OF DEATH a. COUNTY Cecil MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN TB 5 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		d. STREET ADDRESS R.D. # 4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Sarah Middle A. Last Hagerman		4. DATE OF DEATH Month September Day 15 Year 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 9, 1892
9. AGE (in years last birthday) 75 yrs		10. IF UNDER 1 YEAR Months 7 Days 15 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (County & State, or foreign country) West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jake Puckett	
14. MOTHER'S MAIDEN NAME Alafara Hicks		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO		17. INFORMANT Mrs. Elizabeth Pearsall, Elkton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremic Poisoning DUE TO (b) Cerebral Vascular Disease, Diabetes DUE TO (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 7 days 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/14 , 19 67 , to 9/15 , 19 67 , that (I) (we) lost saw the deceased alive on 9/15 , 19 67 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE Rolando A. Najera		22b. DATE SIGNED 9/16/67	
22c. PHYSICIAN'S NAME (Type) Rolando A. Najera		22d. ADDRESS 105 E. Main St. Elkton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/18/67	23c. NAME OF CEMETERY OR CREMATORY Puckett Cemetery	23d. LOCATION (City or Town) (County) (State) Bartley, West Virginia
24. FUNERAL DIRECTOR Alfred E. Hicks Hicks Home for Funerals, Elkton, Md.		25a. REC'D BY REGISTRAR SEP 21 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers—Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12298

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12809



CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb 1 week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS R.D. 5		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELSIE MAY HAMMOND First Middle Last				4. DATE OF DEATH Sept. 5 19 67 Month Day Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 24, 1880	
9. AGE (In years last birthday) 87 yrs		10. UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State or foreign country) Cecil County, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home			
13. FATHER'S NAME Samuel Boyer				14. MOTHER'S MAIDEN NAME Mary L. Biddle			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT Elsie V. Reed		Address R.D. 5 Elkton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO 1810 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Iron deficiency anemia, severe DUE TO (c) Carcinoma of Bladder							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) —							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 28 Aug., 1967 , to 5 Sept., 1967 , that (I) (we) last saw the deceased alive on 5 Sept 1967 , and that death occurred at 3:40 A.M. from causes and on the date stated above.							
22a. SIGNATURE Klaus H. Huebner				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/5/67	
22c. PHYSICIAN'S NAME (Type) KLAUS H. HUEBNER M.D.				22d. ADDRESS NORTH EAST, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 9, 1967		23c. NAME OF CEMETERY OR CREMATORY North East Methodist		23d. LOCATION (City or Town) (County) (State) North East Cecil Md.	
24. FUNERAL DIRECTOR Paul J. Crouch				ADDRESS Box 22 North East, Md.		25a. RECEIVED BY REGISTRAR SEP 11 1967 DATE	
				25b. REGISTRAR'S SIGNATURE [Signature]			

12298

CERTIFICATE OF DEATH

12310

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN TB 72 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital		d. STREET ADDRESS Kennard 223 Kennard Avenue	
3. NAME OF DECEASED (Type or print) First Jerry Middle C. Last HOLECK		4. DATE OF DEATH Month September Day 3 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-15-94
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY US govt. Ret.	
11. BIRTHPLACE (County & State, or foreign country) New York, N.Y.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Holeck		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW I		16. SOCIAL SECURITY NO. 220-20-78-00	
17. INFORMANT Address VA Hospital Records - Perry Point, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Pulmonary Edema, Chronic and Acute 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) Congestive Heart Failure DUE TO (c) Arteriosclerotic coronary heart disease Years			INTERVAL BETWEEN ONSET AND DEATH 5 days 5 months Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that the (this hospital) attended the deceased from 6-23-67 , 19 am to 9-3-67 , 19 pm , and that death occurred at 1:20 M, from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED 9-3-67	
22c. PHYSICIAN'S NAME (Type) IRINA REUS		22d. ADDRESS VA Hospital - Perry Point, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 5, 1967	23c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Church Cemetery	23d. LOCATION (City or Town) (County) (State) Joppa, Maryland
24. FUNERAL DIRECTOR ADDRESS MC COMAS FUNERAL HOME - Abingdon, Maryland		25a. REC'D BY REGISTRAR SEP 6 1967	25b. REGISTRAR'S SIGNATURE 

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

12811

12.000		12811	
1 PLACE OF DEATH a. COUNTY Cecil MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
c. LENGTH OF STAY IN 1b 44 yrs.		d. STREET ADDRESS 115 Collins Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Jane F. Ingram		4 DATE OF DEATH Month Day Year Sept. 8 1967	
5 SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Aug. 3, 1923
9. AGE (In years last birthday) 44 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thomas Ingram	
14. MOTHER'S MAIDEN NAME Lillian Green		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO		17. INFORMANT Address Reta Scott-229 N. Rodney St.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lupus erythematosus disseminata</u> 450 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 5-23-1967, to 9-8-1967, that (I) (we) last saw the deceased alive on 9-7-1967, and that death occurred at 9:30 AM, from causes and on the date stated above.			
22a. SIGNATURE <i>Tillman D. Johnson MD</i>		22b. DATE SIGNED 9-9-67	
22c. PHYSICIAN'S NAME (Type) Tillman D. Johnson MD		22d. ADDRESS 128 Singsley Ave., Elkton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/12/67	23c. NAME OF CEMETERY OR CREMATORY Providence Cem.	23d. LOCATION (City or Town) (County) (State) Elkton, Md.
24 FUNERAL DIRECTOR Colin P. Bell		25a. REC'D BY REGISTRAR DATE SEP 13 1967	
ADDRESS 909 Poplar Street		25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12301

CERTIFICATE OF DEATH

12312

1 PLACE OF DEATH a. COUNTY Cecil MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Penna b. COUNTY Chester	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville		c LENGTH OF STAY IN 1b 34 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA HOSPITAL PERRY POINT, MD.		d. STREET ADDRESS 213 W. 9th Street	
3 NAME OF DECEASED (Type or print) First Middle Last AUSTIN P JACKSON		4. DATE OF DEATH Month Day Year September 18, 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-5-95
9. AGE (In years lost birthday) 71 yrs		10. IF UNDER 1 YEAR Months Days Hours Min 18 18 18 18	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11 BIRTHPLACE (County & State, or foreign country) Port Deposit, Md.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME J. Wesley Jackson (Deceased)		14. MOTHER'S MAIDEN NAME Leona Woodrow (Deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW I		16 SOCIAL SECURITY NO 178-07-5614	
17. INFORMANT Address VA Hospital records, Perry Point, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema with massive pleural effusion DUE TO (b) Acute & chronic myocardial infarctions DUE TO (c) Coronary thrombosis-Arteriosclerotic heart disease -- INTERVAL BETWEEN ONSET AND DEATH -----			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Aug 15, 1967 , to Sept. 18, 1967 , and that death occurred on 9:30 PM , from causes and on the date stated above.			
22a SIGNATURE A. L. Mooney		22b DATE SIGNED 9-19-67	
22c PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D.		22d ADDRESS VA HOSPITAL,, PERRY POINT, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCAT ON (City or Town) (County) (State)
Burial	Sept. 22, 1967	Hopewell Cemetery	Port Deposit, Md.
24. FUNERAL DIRECTOR Patterson Funeral Home		25a. REC'D BY REG STRAR DATE SEP 26 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 7 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item 23b-25M 1/67 9/20/67 kk									
12302									
CERTIFICATE OF DEATH									
12313									
1 PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md. c. LENGTH OF STAY IN b 4 days 1 yr 9 mos d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital					2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Ohio b. COUNTY Cleveland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cleveland d. STREET ADDRESS 9105 Birchdale Avenue e. IS RES. DENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last OLIN W. KELSEY					4. DATE OF DEATH Month Day Year September 8 1967				
5 SEX Male		6. COLOR OR RACE Negro		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 4-5-94		9 AGE (In years last birthday) yrs 73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) Unknown			12 CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William					14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I			16. SOCIAL SECURITY NO 220-54-6140		17. INFORMANT Address VA Hospital Records, Perry Point, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema DUE TO (b) Acute Myocardial Infarction DUE TO (c) Arteriosclerotic Heart Disease, Severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH 6-8 days Years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home farm factory, street, office bldg, etc.)		20f. (City or town) (County) (State)			
21. I certify that XX this hospital attended the deceased from Dec. 8, 1965 to Sept. 8, 1967 , that I personally saw the deceased alive on 19 and that death occurred at 2:40 A.M. from causes and on the date stated above.									
22a. SIGNATURE A. L. Mooney					M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D.					22d. ADDRESS VA Hospital, Perry Point, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 9-12-67		23c. NAME OF CEMETERY OR CREMATORY Baltimore National			23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		
24. FUNERAL DIRECTOR Carroll Funeral Home, 1529 E. North Ave.,					ADDRESS Balto., Md.		25a. REC'D BY REGISTRAR DATE SEP 26 1967		25b. REGISTRAR'S SIGNATURE

12303

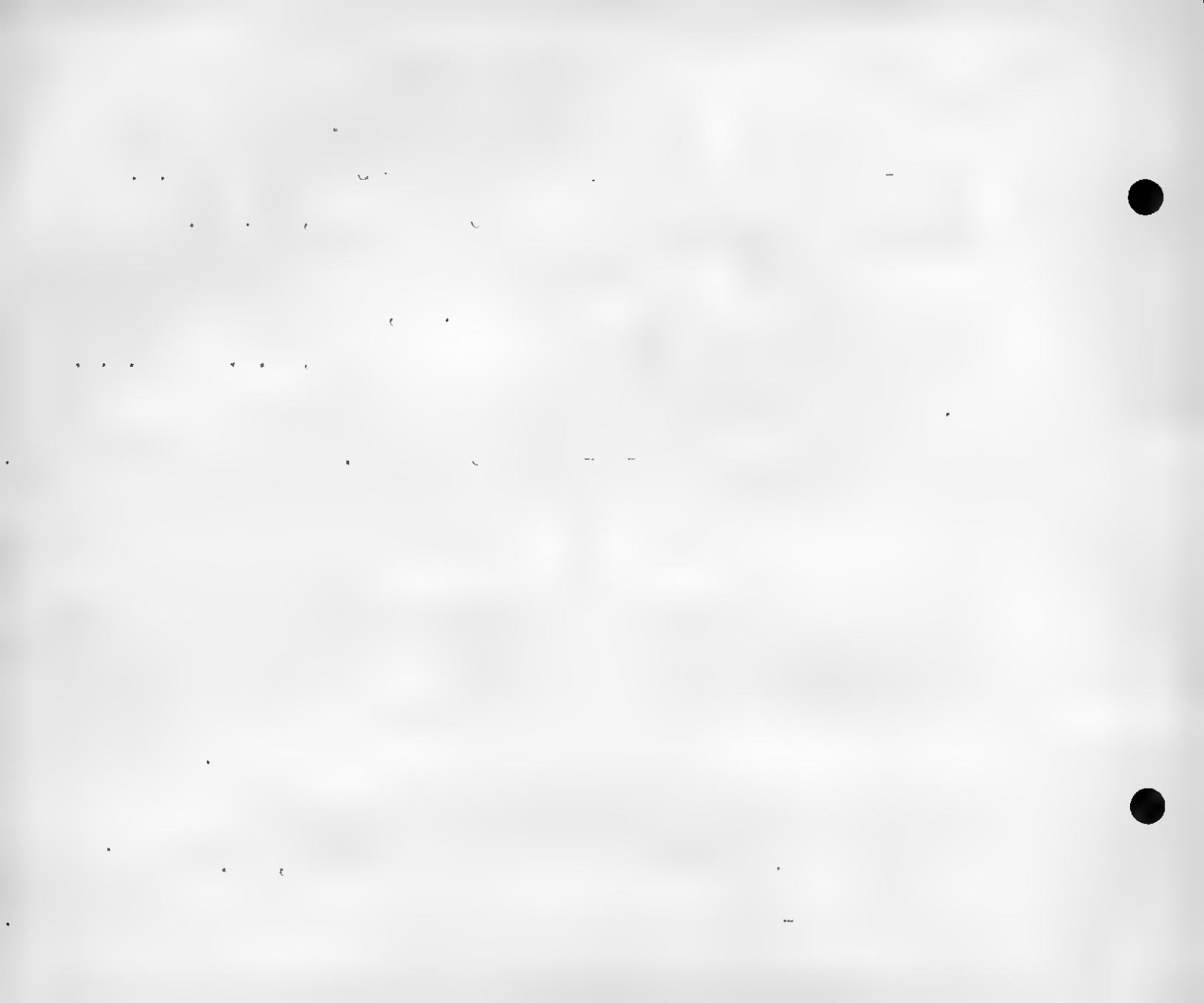
CERTIFICATE OF DEATH

12314

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Penna. b. COUNTY Chester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Rising Sun RD		c. LENGTH OF STAY IN 1b 4 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert Manor Nursing Home		d. STREET ADDRESS Cochranville, Pa. RD. 2	
3 NAME OF DECEASED (Type or print) Susie Masters Lewis		4 DATE OF DEATH Month September Day 19 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Aug. 23, 1877
9. AGE (In years last birthday) 90 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11 BIRTHPLACE (County & State or foreign country) Bakersville, N.C.		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME T. Dawson Masters		14. MOTHER'S MAIDEN NAME Polly Peterson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 167-30-4228D	
17 INFORMANT Chester R. Lewis - Lincoln Univ Pa.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial infarction DUE TO ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March , 19 65 , to Sept. , 19 67 that (I) did last saw the deceased alive on Sept. 19, 1967 , and that death occurred at 10 M, from causes and on the date stated above.			
22a. SIGNATURE Guy T. Holcombe		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Guy T. Holcombe		22d. ADDRESS 57 North Fourth St. Oxford, Pa.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-28-1967	23c. NAME OF CEMETERY OR CREMATORY Faggs Manor Cemetery	23d. LOCATION (City or Town) (County) (State) Cochranville-Chester-Pa.
24. FUNERAL DIRECTOR William J. Johnson		25a. REC'D BY REGISTRAR SEP 25 1967	
		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12304

CERTIFICATE OF DEATH

137771

1 PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Solomons Island	
c. LENGTH OF STAY IN 1b 220 days		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Francis Middle H. Last Lore		4 DATE OF DEATH Month September Day 29 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/20/95
9 AGE (In years last birthday) 72 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter - Retired	
10b. KIND OF BUSINESS OR INDUSTRY Construction		11 BIRTHPLACE (County & State, or foreign country) Calvert Co., Maryland	
12 CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph C. Lore	
14. MOTHER'S MAIDEN NAME Sarah Tucker		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes NWI	
16 SOCIAL SECURITY NO 577-12-37-50		17. INFORMANT Address Hospital records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral DUE TO (b) Congestive Heart Failure DUE TO (c) Arteriosclerotic Heart Disease with Myocardial fibrosis			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral Infarct, right			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (1) (this hospital) attended the deceased from Feb. 21 , 19 67 , to Sept. 29 , 19 67 and that death occurred 10:15 M. from causes and on the date stated above.			
22a. SIGNATURE A. L. Mooney M.D.		22b. DATE SIGNED 9-29-67	
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D.		22d. ADDRESS VA Hospital, Perry Point, Md.	
23a. BURIAL OR REMOVAL SPECIES Removal	23b. DAY THEREOF Oct 3, 1967	23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l Cem.	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Patterson Funeral Home, Perryville, Md.		25a. REC'D BY REGISTRAR DATE OCT 9 1967	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

19305

CERTIFICATE OF DEATH

12315

1 PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN b 5 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Elkton d. STREET ADDRESS R.D. 5 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) ANDREA MAHONEY		4. DATE OF DEATH Month Sept. Day 22 Year 19 67	
5 SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH March 3, 1944
9 AGE (In years last birthday) 23 yrs.		10 IF UNDER 1 YEAR Months 1 Days 19 Hours 67 Min.	
10a USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) File Clerk		10b KIND OF BUSINESS OR INDUSTRY Civil Service	
11 BIRTHPLACE (County & State, or foreign country) Montgomery Co. Penna.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Newton H. Mahoney Jr.		14 MOTHER'S MAIDEN NAME Irene K. Osenbach	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO. 215-42-9623	
17 INFORMANT Newton H. Mahoney Jr.		Address R.D. 5 Elkton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Rt. and Left Auricular and Ventricular Hypertrophy DUE TO (b) Pulmonary Hypertension DUE TO (c) Dilatation of main central pulmonary arteries, cause unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH 2 years 2 years (?) 5 years (?)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from 2 Oct , 19 65 to 22 Sept , 19 67 , that (1) (we) last saw the deceased alive on 9/22 , 19 67 , and that death occurred at 5:40 P.M. , from causes and on the date stated above			
22a. SIGNATURE Klaus H. Huebner		22b. DATE SIGNED 9/22/67	
22c. PHYSICIAN'S NAME (Type) KLAUS H. HUEBNER		22d. ADDRESS NORTH EAST, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-26-67	23c. NAME OF CEMETERY OR CREMATORY Union Cemetery	23d. LOCATION (City or Town) (County) (State) Elkton Cecil Md.
24. FUNERAL DIRECTOR Grant Funeral Home		25a. REC'D BY REGISTRAR SEP 26 1967	
25b. REGISTRAR'S SIGNATURE John J. Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12306

12316

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY CECIL MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE Maryland b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN (b) Colora	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		d. STREET ADDRESS RD #1	
3 NAME OF DECEASED (Type or print) First JAMES Middle WILLIAM Last MARTIN, JR.		4 DATE OF DEATH Month September Day 29 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH DEC. 11, 1942
9 AGE (In years lost birthday) 24 yrs		10 IF UNDER 1 YEAR Months 24 Days 24 Hours 24 Min 24	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ASSEMBLY LINE		10b. KIND OF BUSINESS OR INDUSTRY AUTOMOBILE	
11. BIRTHPLACE (State or foreign country) WILLOW GROVE, TENN.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME JAMES W. MARTIN		14 MOTHER'S MAIDEN NAME NORA LEDBETTER	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16 SOCIAL SECURITY NO 214-42-1698	
17 INFORMANT JAMES W MARTIN, COLORA, MD.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY 16.4 IMMEDIATE CAUSE (a) Multiple traumatic injuries DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY CAUSE OF DEATH <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Driver in auto-auto collision	
20c. TIME OF INJURY Month, Day, Year 6:00 AM 9-29 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) highway		20f. (City or town) CALVERT (County) CECIL (State) MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MED. CAL. EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MED. CAL. EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county)	
22 DATE SIGNED September 29, 1967			
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10/4/67	23c. NAME OF CEMETERY OR CREMATORY FELLOWSHIP CEM.	23d. LOCATION (City or Town) (County) (State) COCKEVILLE OVERTON TENN.
24 FUNERAL DIRECTOR RALPH M. REED Ralph M Reed		ADDRESS RISING SUN, MD.	
25a. REC'D BY REGISTRAR OCT 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12307

CERTIFICATE OF DEATH

12317

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on, Residence before admission) a. STATE Maryland b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) ELKTON		c. LENGTH OF STAY IN TB 2 WEEKS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NORTH EAST		d. STREET ADDRESS 122 S MAIN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) UNION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SMITH Cooper Mc Ginnes		4. DATE OF DEATH Month 9 Day 16 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3-17-93
9. AGE (In years last birthday) 74 yrs		10. IF UNDER 1 YEAR Months 13 Days 13 Hours 1 Min 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES		10b. KIND OF BUSINESS OR INDUSTRY SEAFOOD	
11. BIRTHPLACE (County & State, or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN MCGINNES		14. MOTHER'S MAIDEN NAME MARY LOU NICKERSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 200-09-8435	
17. INFORMANT ELSIE M. WELLER		Address NORTH EAST MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary Edema DUE TO (c) Diarrhea with Rectal Bleeding		INTERVAL BETWEEN ONSET AND DEATH 13-Days 13-Days 1-Day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS A TOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/3/ , 19 67 , to 9/16/ , 19 67 , that (I) (we) saw the deceased alive on 9/16/ , 19 67 , and that death occurred at 5:45 A.M. from causes on and on the date stated above.			
22a. SIGNATURE James L. Johnson M.D.		22b. DATE SIGNED 9/18/67	
22c. PHYSICIAN'S NAME (Type) James L. Johnson M.D.		22d. ADDRESS 245 E. High, St. Elkton Cecil Md.	
23a. BURIAL, CREMATION REMOVAL (Specify) BURIAL	23b. DATE THEREOF 9-19-67	23c. NAME OF CEMETERY OR CREMATORY NORTH EAST METH.	23d. LOCATION (City or Town) (County) (State) NORTH EAST CECIL MD
24. FUNERAL DIRECTOR GRANT FUNERAL HOME		25a. REC'D BY REGISTRAR SEP 19 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban pages 1 and 2. should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



12308

CERTIFICATE OF DEATH

12318

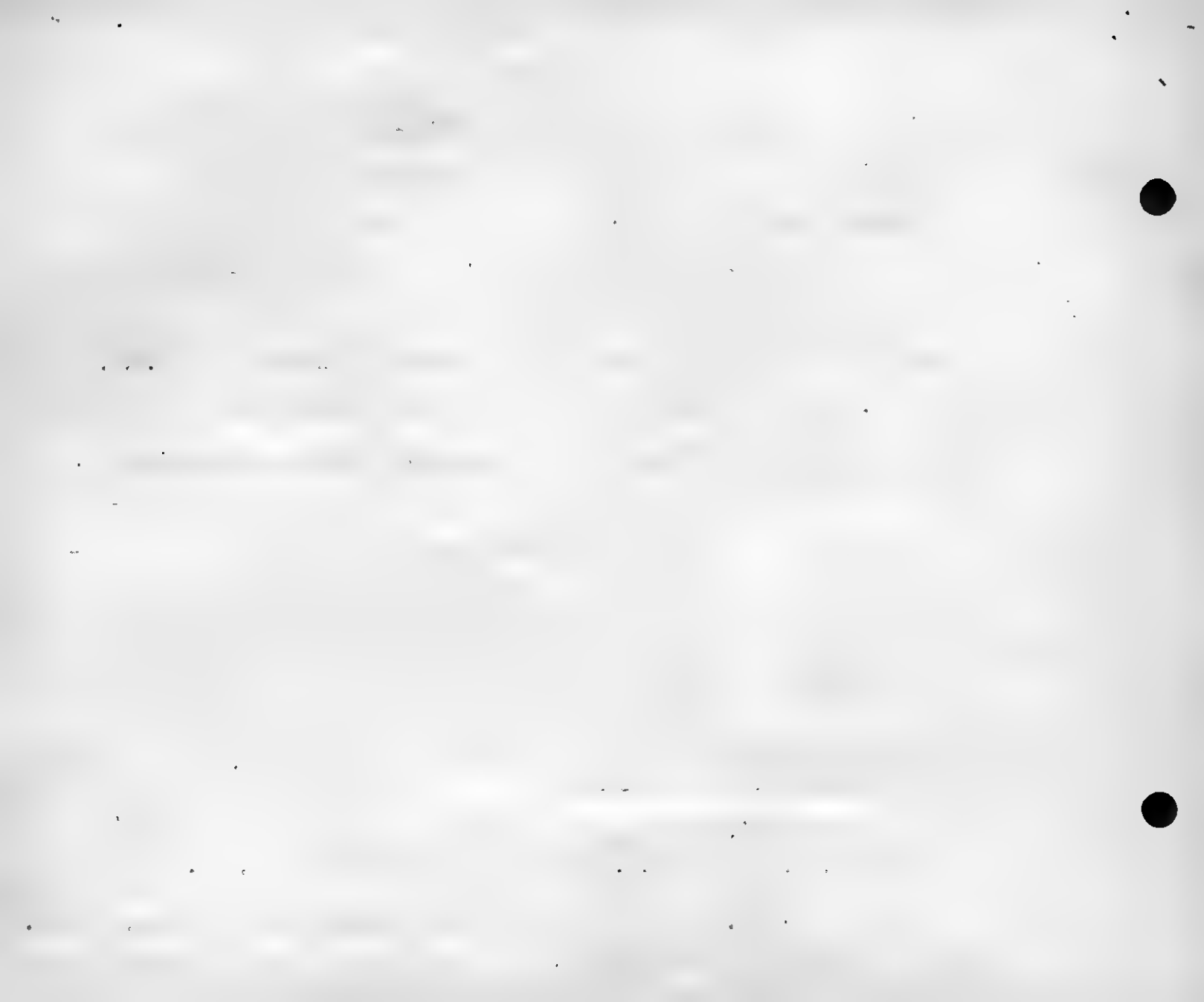
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		c. LENGTH OF STAY IN 1b 55 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 222 East Thomas Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) REED CULBERSTON McKinney		4. DATE OF DEATH Month Sept. Day 26 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1892
9. AGE (In years last birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman	
11. BIRTHPLACE (County & State, or foreign country) Cecil Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Stephen W. McKinney		14. MOTHER'S MAIDEN NAME Mary Mahoney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO	
17. INFORMANT Edgar R. McKinney		Address North East, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LEFT LUNG DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardiovascular Disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) _____	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) (County) (State) _____
21. I certify that (I) (this hospital) attended the deceased from 5/31, 1967 , to 9/26, 1967 , that (I) (we) last saw the deceased alive on 9/14, 1967 , and that death occurred at 3A. M. from causes and on the date stated above			
22a. SIGNATURE Klaus H. Huebner		22b. DATE SIGNED 9/26/67	
22c. PHYSICIAN'S NAME (Type) KLAUS H. HUEBNER		22d. ADDRESS NORTH EAST, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-29-67	23c. NAME OF CEMETERY OR CREMATORY North East Methodist	23d. LOCATION (City or Town) (County) (State) North East Cecil Md.
24. FUNERAL DIRECTOR Grant Funeral Home		25a. REC'D BY REGISTRAR SEP 28 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

12303				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				12319			
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 27 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital, Perry Point, Md.				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen d. STREET ADDRESS Box 92 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Herbert Clinton McVey				4. DATE OF DEATH Month Day Year September 7 19 67							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-18-89		9. AGE (In years last birthday) yrs. 78		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (County & State, or foreign country) Edgewood, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John J. McVey (D)				14. MOTHER'S MAIDEN NAME Martha Hopper Hoopes (D)							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 217-16-1947		17. INFORMANT VA Hospital Records, Perry Point, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO (b) Congestive heart failure DUE TO (c) Arteriosclerotic heart disease CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH 5-6 hours - years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that XXXXXXXXXXXXXXXXXXXX attended the deceased from August 11 , 19 67 , to Sept. 7 , 19 67 XXXXXXXXXXXXXXXXXXXX and that death occurred at 7:50pm , from causes and on the date stated above.											
22a. SIGNATURE A. L. Mooney				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 9-8-67			
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D.				22d. ADDRESS VAH, Perry Point, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-Sep.-67		23c. NAME OF CEMETERY OR CREMATORY St Paul Lutheran Cemetery, Aberdeen, Md.		23d. LOCATION (City or Town) (County) (State)					
24. FUNERAL DIRECTOR TARRING FUNERAL HOME, Aberdeen, Md.				25a. REC'D BY REGISTRAR SEP 11 1967		25b. REGISTRAR'S SIGNATURE Charles George					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DEL.</u> b. COUNTY <u>NEW CASTLE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>	c. LENGTH OF STAY IN 1b <u>153 DAYS</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEAR</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>UNION HOSPITAL</u>		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>B.</u> Last <u>MOORE</u>		4. DATE OF DEATH Month <u>SEPT.</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. B. DATE OF BIRTH <u>MARCH 28, 1895</u>
9. AGE (In years last birthday) <u>72</u> yrs		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>18</u> Hours <u>19</u> Min.	
11. US. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		12. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
13. FATHER'S NAME <u>GEORGE MOORE</u>		14. MOTHER'S MAIDEN NAME <u>MARY C. WHITE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>YES WW#1</u>		16. SOCIAL SECURITY NO <u>222-22-0358A</u>	
17. INFORMANT <u>FRANCIS H. MOORE-BEAR, DEL</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral abscess</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ruptured diverticulum of sigmoid Colon</u> DUE TO (c) <u>Diverticulitis of Colon</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>2 months</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9-17</u> , 1967, to <u>9-18</u> , 1967, that (I) (we) lost saw the deceased alive on <u>9-17</u> 1967, and that death occurred at <u>1135AM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>Willford Eppes</u>		22b. DATE SIGNED <u>9-21-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>WILLFORD EPPES</u>		22d. ADDRESS <u>327 E. MAIN ST. NEWARK, DEL.</u>	
23a. BURIAL, CREMATION, REMOVED (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9/21/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PRESBYTERIAN CEM</u>	23d. LOCATION (City or town) (County) (State) <u>CHRISTIANNA DEL.</u>
24. FUNERAL DIRECTOR <u>PIPPIN FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>SEP 20 1967</u>	
ADDRESS <u>ELKTON MD</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12311

12321

1 PLACE OF DEATH a. COUNTY Cecil MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb Rural, Elk Mills, Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital Of Cecil County		d. STREET ADDRESS 6 IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last Baby Ruby Ruth Nichols		4. DATE OF DEATH Month Day Year 9 15 19 67	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/10/67
9 AGE (In years last birthday) yrs 5		IF UNDER 1 YEAR Months Days Hours Min 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Larry Eugene Nichols		14. MOTHER'S MAIDEN NAME Ruby Jane Biggs	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO -----	
17. INFORMANT Mrs. Larry Nichols (Mother)		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Brain Damage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Sub temporal hemorrhage DUE TO (c) Anoxemia			INTERVA. BETWEEN ONSET AND DEATH 5. Days 4 days 4 days
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 9/10/ , 19 67 , to 9/15/ , 19 67 , that (I) (we) last saw the deceased alive on 9/15/ , 19 67 , and that death occurred at 2 A. M, from causes and on the date stated above.			
22a. SIGNATURE James L. Johnson		22b. DATE SIGNED 9/15/67	
22c. PHYSICIAN'S NAME (Type) James L. Johnson M.D.		22d. ADDRESS 245 E. High St., Elkton Cecil Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/16/67	
23c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		23d. LOCATION (City or Town) (County) (State) Elkton, Md.	
24. FUNERAL DIRECTOR Hicks Home for Funerals, Elkton, Md.		25a. REC'D BY REGISTRAR DATE SEP 21 1967	
25b. REGISTRAR'S SIGNATURE James L. Johnson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



12312

CERTIFICATE OF DEATH

12322

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN Ib <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>		d. STREET ADDRESS <u>186 Hollingsworth Manor</u>	
3. NAME OF DECEASED (Type or print) <u>Clarence</u> First <u>Edker</u> Middle <u>Odum</u> Last		4. DATE OF DEATH <u>Sept.</u> Month <u>27</u> Day <u>67</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16, 1907</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 17, IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Aid</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>V.A. Hospital</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Bristol, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Odum</u>		14. MOTHER'S MAIDEN NAME <u>Daisy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give year or dates of service) <u>WW #2</u>		16. SOCIAL SECURITY NO. <u>225-03-3198</u>	
17. INFORMANT <u>Mrs. Ruth J. Odum, Elkton, Maryland.</u>		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> DUE TO (b) <u>Coronary Artery Disease</u> DUE TO (c) <u>I A I D</u>			INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/10/67</u> , 19 <u>67</u> , to <u>9/27/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/27/67</u> , and that death occurred at <u>12:52</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>9/27/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>PIPPIN STARRAKIS, M.D.</u>		22d. ADDRESS <u>ELKTON, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-30-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Elkton Cecil Md.</u>
24. FUNERAL DIRECTOR <u>PIPPIN FUNERAL HOME, Donald M. Pippin, Elkton, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 25 1967</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in an event, within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

12313

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12323

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY CECIL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) UNION HOSPITAL				d. STREET ADDRESS Road 13, Hollingsworth Manor		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KENNETH HOMER RICE				4. DATE OF DEATH Month September Day 26 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH SEPT. 30, 1943		9. AGE (In years last birthday) 23 yrs	IF UNDER 1 YEAR Months 23 Days 25 Hours 19 Min 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) ELK PAPER		10b. KIND OF BUSINESS OR INDUSTRY DRIVER		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WALTER RICE				14. MOTHER'S MAIDEN NAME ELSIE HICKMAN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 213-42-4063		17. INFORMANT BERTHA M. RICE Address ELKTON, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple traumatic injuries DUE TO 11-3 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Pulled into paper rollers					
20c. TIME OF INJURY Month, Day, Year 3:00 a.m. 9-26 1967		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) factory		20f. (City or town) (County) (State) Elkton CECIL MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspect on <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate		EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED September 26, 1967 Address (Street, city, town, or county)	
23a. BURIAL CREMATION (Specify) BURIAL		23b. DATE THEREOF SEPT. 30, 1967		23c. NAME OF CEMETERY OR CREMATORY GILPIN MANOR MEM PK		23d. LOCATION (City or Town) (County) (State) ELKTON, MD.	
24. FUNERAL DIRECTOR PIDDIN FUNERAL HOME				25a. RECD BY REGISTRAR SEP 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

12314

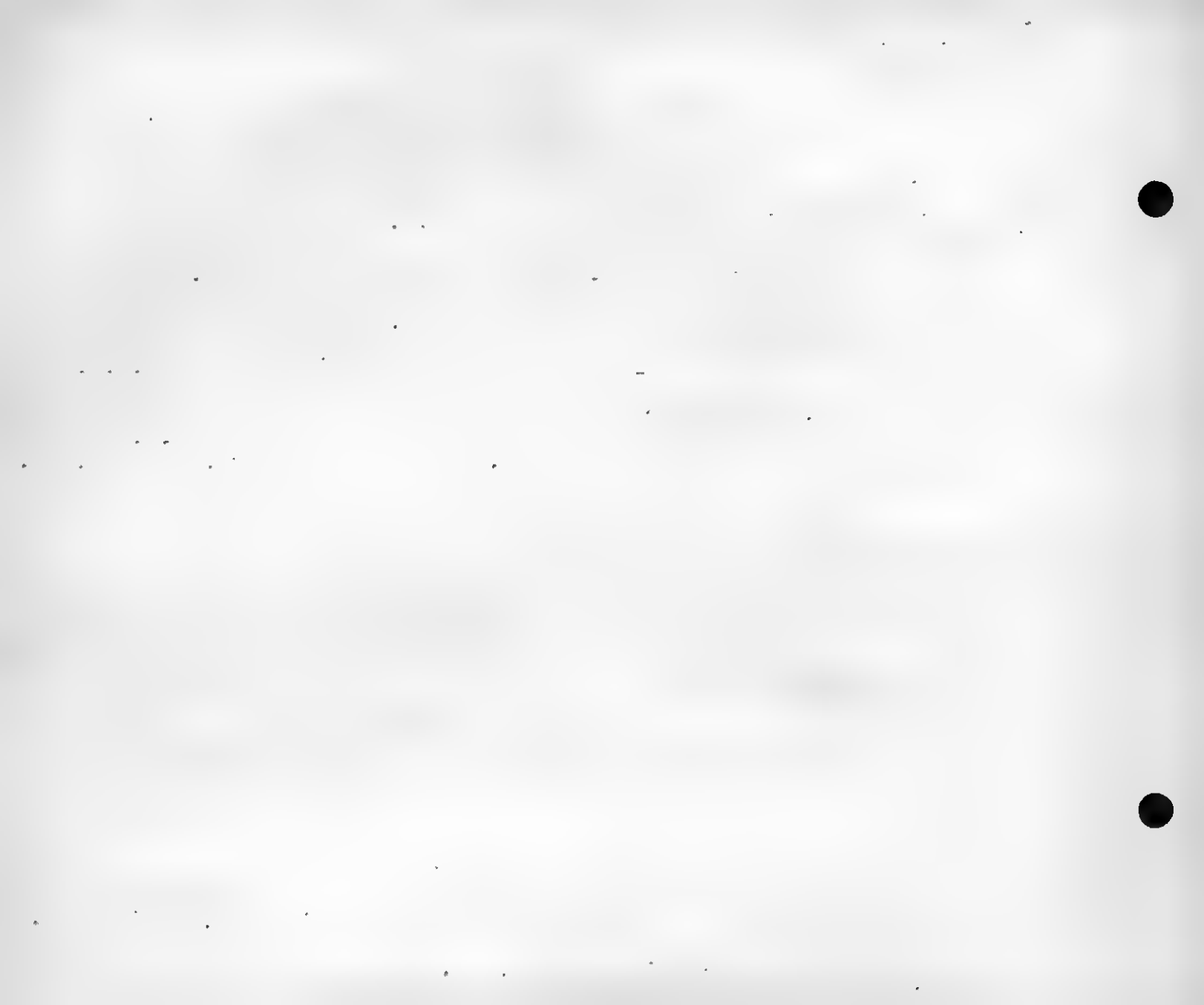
CERTIFICATE OF DEATH

12324

1 PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN lb 1 day d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton d. STREET ADDRESS R.D. # 4 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Alice A. Scarborough		4 DATE OF DEATH Month Sept. Day 22 Year 1967	
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 18, 1904
9. AGE (In years last birthday) 63 yrs		10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11 BIRTHPLACE (County & State, or foreign country) Pennsylvania		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Howard Spencer Gerber		14. MOTHER'S MAIDEN NAME Mattie Throne	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO ---	
17. INFORMANT T. Alfred Scarborough, Elkton, Md.		Address R.D. 4	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO (b) Coronary artery thrombosis DUE TO (c) Arteriosclerotic Heart Disease CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 18h. 18h. Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-21-1967 to 9-22-1967 , that (I) (we) last saw the deceased alive on 9-22-1967 , and that death occurred at 12:45 P.M. from causes and on the date stated above			
22a. SIGNATURE T. William D. Johnson M.D.		22b. DATE SIGNED 9-25-67	
22c. PHYSICIAN'S NAME (Type) T. William D. Johnson M.D.		22d. ADDRESS 123 Singler Ave. Elkton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 9/25/67	23c. NAME OF CEMETERY OR CREMATORY Sharps Cemetery	23d. LOCATION (City or town) (County) (State) Elkton, Md.
24. FUNERAL DIRECTOR Ralph E. Hicks		25a. REC'D BY REGISTRAR SEP 28 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS Hicks Home for Funerals, Elkton, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



12315

CERTIFICATE OF DEATH

12325

1 PLACE OF DEATH a. COUNTY Cecil MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bay View		c. LENGTH OF STAY IN lb 1 month	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, R. D. 4, Elkton, Md.	
		d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Susan J. Schaible		4 DATE OF DEATH Month Sept. Day 14 Year 19 67	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 17, 1891
9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR Months 14 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Cecil County, Maryland U.S.A.		12 CITIZEN OF WHAT COUNTRY?	
13 FATHER'S NAME Samuel Reynolds Guiberson		14. MOTHER'S MAIDEN NAME Susan Jane Hammond	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO.	
17. INFORMANT Raymond Guiberson, Bay View, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) Arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) County coroner, Dr. John Byers, was called & notified of death			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from X , 19 67 , to X , 19 67 , that (I) (we) last saw the deceased alive on X , 19 67 , and that death occurred at 11:30 PM , from causes and on the date stated above.			
22a. SIGNATURE Jay S. Barnhart, Jr.		22b. DATE SIGNED 9-16-67	
22c. PHYSICIAN'S NAME (Type) Jay S. Barnhart, Jr. M.D.		22d. ADDRESS 3 Mauldin Avenue, North East, Md.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 18, 1967	23c. NAME OF CEMETERY OR CREMATORY Cherry Hill Meth. Cem.	23d. LOCATION (City or town) Elkton, Md. (State) Cecil
24 FUNERAL DIRECTOR Hicks Home for Funerals, Elkton, Md.		25a. RECEIVED BY REGISTRAR DATE SEP 21 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove forgon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 of this certificate should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12315

12326

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) North East c. LENGTH OF STAY IN 1b 45 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 115 Wallace Ave.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) North East d. STREET ADDRESS 115 Wallace Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sarah Middle Lucille Last Shepherd 4. DATE OF DEATH Month Sept. Day 15 Year 1967		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Sept. 19, 1885 9. AGE (in years last birthday) 81 yrs. IF UNDER 1 YEAR: Months 81 Days 15 Hours 15 Min. 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Home 11. BIRTHPLACE (County & State, or foreign country) Jackson Co. Ky. 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Richard Hayes 14. MOTHER'S MAIDEN NAME Sarah Engle 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No 16. SOCIAL SECURITY NO. James E. Shepherd 17. INFORMANT James E. Shepherd Address 102 Jethro St. North East, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic congestive heart failure DUE TO Senile and arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senile and arteriosclerotic cardiovascular disease (c) Diabetes mellitus, controlled hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus, controlled hypertension			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 9-15 Hour a.m. 19 p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from 8-22 , 19 67 to 9-15 , 19 67 , that (2) (we) last saw the deceased alive on 9-15 , 19 67 , and that death occurred at 3:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE Jay S. Barnhart Jr. 22b. DATE SIGNED 9-15-67 22c. PHYSICIAN'S NAME (Type) Jay S. Barnhart Jr. 22d. ADDRESS 4 Mauldin Ave. North East, Md. 22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22f. ADDRESS 4 Mauldin Ave. North East, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 9-18-67 23c. NAME OF CEMETERY OR CREMATORY North East Methodist 23d. LOCATION (City, town or county) (State) North East Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Robert Hoang ADDRESS Box 22 North East, Md. 25. REC'D BY REGISTRAR SEP 19 1967 25b. REGISTRAR'S SIGNATURE Charles Judge			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

VR A15ME (1)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12317

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12327

1 PLACE OF DEATH a COUNTY Cecil MARYLAND		2 USUAL RESIDENCE (Where deceased lived) a. STATE MD. b. COUNTY Cecil	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Hack's Point		c LENGTH OF STAY IN b DOA	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e STREET ADDRESS Oldfield Point Road	
3 NAME OF DECEASED (Type or print) Michael John Sherlock, Jr.		4 DATE OF DEATH Month 9 Day 9 Year 1967	
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 22, 1948
9a AGE (In years last birthday) 18 yrs		9b IF UNDER 1 YEAR Months 18 Days 18 Hours 18 Min 18	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b KIND OF BUSINESS OR INDUSTRY School	
11 BIRTHPLACE (State or foreign country) Delaware		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Michael John Sherlock, Sr.		14 MOTHER'S MAIDEN NAME Elizabeth Marie deHan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Michael J. Sherlock, Sr. Elkton, Md.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Crushing of Chest DUE TO (b) Automobile Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Pressed against steering wheel in 2-car collision	
20c TIME OF INJURY Month, Day, Year 1:05 - 9-9-1967		20d INJURY OCCURRED While <input type="checkbox"/> at work <input checked="" type="checkbox"/> not while at work	
20e PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) Rte 213 Hwy.		20f (City or town) (County) (State) Mr. Bohemio R. Bridge Cecil, Md.	
21 I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John M. Byers, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John M. Byers, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) Elkton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/12/67	
23c. NAME OF CEMETERY OR CREMATORY Immaculate Conception		23d. LOCATION (City or Town) (County) (State) Cherry Hill, Md.	
24 FUNERAL DIRECTOR Ralph E. Hicks		25a REC'D BY REGISTRAR SEP 14 1967	
Address Hicks Home for Funerals, Elkton, Md.		25b REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 14
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
12318 Item #23c Film #3322 9/20/67 ph 12328											
1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN lb <u>16 Hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>						d. STREET ADDRESS <u>6 Curtis Lane</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)			First <u>Paul</u> Middle <u>Theodore</u> Last <u>Simmons</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>8</u> Year <u>1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 26, 1911</u>		9. AGE (In years last birthday) <u>56</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Elkton, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Simmons</u>						14. MOTHER'S MAIDEN NAME <u>Mary Dick</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>216-01-4589</u>		17. INFORMANT Address <u>Mrs. Vivian Simmons, Elkton, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary insufficiency</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u> </u> (b) <u>Calcific Aortic stenosis</u> DUE TO <u> </u> (c) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u>24 hr</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1-6</u> , 19 <u>66</u> , to <u>9-8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9-7</u> 19 <u>67</u> , and that death occurred at <u>12:35</u> A.M., from causes on and on the date stated above.											
22a. SIGNATURE <u>Williford Eppes</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>9-9-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Williford Eppes, M.D.</u>						22d. ADDRESS <u>Newark, Delaware</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>9-12-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gilpin Manor Mem. Park</u>				23d. LOCATION (City or Town) (County) (State) <u>Elkton, Cecil, Md.</u>	
24. FUNERAL DIRECTOR <u>PIPPIN FUNERAL HOME Donald H. Dee Elkton, Md.</u>						25a. REC'D BY REGISTRAR DATE <u>SEP 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

CERTIFICATE OF DEATH

12318

12329

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Childs c. LENGTH OF STAY IN TB 40 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Childs d. STREET ADDRESS 07-1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Cora A. Simpson		4. DATE OF DEATH Month Day Year Sept. 23, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1874
9. AGE (In years last birthday) 92 yrs		10. IF UNDER 1 YEAR Months Days Hours Min 12	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles W. Howeth		14. MOTHER'S MAIDEN NAME Annie Ford	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO ---	
17. INFORMANT Mrs. Gertrude G. Walker, Childs, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO (b) 7 + 00 DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan, 1960 , to Sept 23, 1967 , that (I) (we) lost saw the deceased alive on Sept. 23, 1967 , and that death occurred at 3 A.M. , from causes and on the date stated above.			
22a. SIGNATURE Tillman D. Johnson M.D.		22b. DATE SIGNED 4-23-67	
22c. PHYSICIAN'S NAME (Type) Tillman D. Johnson M.D.		22d. ADDRESS 123 Sinsley Ave., Elkton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/27/67	23c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery	23d. LOCATION (City or Town) (County) (State) Elkton, Md.
24. FUNERAL DIRECTOR Ralph E. Hicks		25a. REC'D BY REGISTRAR SEP 28 1967	
ADDRESS Hicks Home for Funerals, Elkton, Md.		25b. REGISTRAR'S SIGNATURE James J. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12330

CERTIFICATE OF DEATH

12330

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE Delaware b. COUNTY N.C.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Newark		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS Sunset Lake Road		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) First Michael Middle P. Last Toomey				4. DATE OF DEATH Month Sept. Day 26 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 25, 1912	
9. AGE (In years last birthday) 55 yrs.		10. IF UNDER 1 YEAR Months 1 Days 19 Hours 19 Min.		11. BIRTHPLACE (County & State, or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemical mixer				10b. KIND OF BUSINESS OR INDUSTRY Chemical		13. FATHER'S NAME Hugh J. Toomey	
13. FATHER'S NAME Hugh J. Toomey				14. MOTHER'S MAIDEN NAME Catherine C. Kelleher			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service)		16. SOCIAL SECURITY NO 221-09-1645		17. INFORMANT Mrs. Doris Prettyman Address Newark, Delaware			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory Failure DUE TO (b) Pneumonia DUE TO (c) Heart							INTERVAL BETWEEN ONSET AND DEATH 1 week
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prostate							19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/25 , 19 67 , to 9/26 , 19 67 , that (I) (we) last saw the deceased alive on 9/25 , 19 67 , and that death occurred at 11:00 AM, from causes and on the date stated above.							
22a. SIGNATURE Peter Stavrakis				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 9/26/67	
22c. PHYSICIAN'S NAME (Type) PETER STAVRAKIS				22d. ADDRESS ELKTON MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 29, 1967		23c. NAME OF CEMETERY OR CREMATORY St. John's Cem.		23d. LOCATION (City or Town) (County) (State) Newark, Delaware	
24. FUNERAL DIRECTOR R.T. Jones				ADDRESS Newark, Delaware		25a. REC'D BY REGISTRAR SEP 29 1967	
				25b. REGISTRAR'S SIGNATURE Charles J. Jones			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

• •

—

— •

+

•

•

•

•

•

•

—

—

•

•

•

•

•

•

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12321

CERTIFICATE OF DEATH

12331

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN Ib <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>		d. STREET ADDRESS <u>179 Hollingsworth Manor</u>	
3. NAME OF DECEASED (Type or print) <u>BLANCHE MAE TWEED</u>		4. DATE OF DEATH <u>September 14, 1967</u>	
SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 23, 1904</u>
9. AGE (In years last birthday) <u>63</u> yrs		IF UNDER 1 YEAR: Months <u>14</u> Days <u>19</u> Hours <u>67</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>North East, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Mc Dowell</u>		14. MOTHER'S MAIDEN NAME <u>Emma Logal</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-22-8946</u>	
17. INFORMANT <u>Lester E. O'Brien Elkton, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>Coronary Occlusion</u> DUE TO (c) <u>HAES</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u> <u>10 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Marked Obesity</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> to <u>9/14</u> , 1967, that (I) (we) last saw the deceased alive on <u>1967</u> , and that death occurred at <u>12:12</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>Peter Stavrakis</u>		22b. DATE SIGNED <u>9/15/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Peter Stavrakis</u>		22d. ADDRESS <u>W. Main St., Elkton, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept. 17, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Newark Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Newark, Delaware</u>
24. FUNERAL DIRECTOR <u>PIPPIN FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>SEP 20 1967</u>	
ADDRESS <u>Elkton, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

12322

12332

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Cecil MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE DISTRICT OF COLUMBIA	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 5 Yrs 7-Mo 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital		d. STREET ADDRESS 3704 30th Pl N.E.	
3 NAME OF DECEASED (Type or print) First Middle Last Claude W. UNDERWOOD		4 DATE OF DEATH Month Day Year September 24, 1967	
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-28-00
9. AGE (In years lost birthday) yrs 67		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer	
11. BIRTHPLACE (County & State, or foreign country) N. Y. N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13 FATHER'S NAME Charles Underwood (Deceased)		14. MOTHER'S MAIDEN NAME Lola Nolan (Deceased)	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 534-28-67-16	
17 INFORMANT Address VA Hospital Records - Perry Point, Maryland			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO (b) coronary occlusion DUE TO (c) Arteriosclerotic heart disease, severe			INTERVAL BETWEEN ONSET AND DEATH 4-7 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (1) (this hospital) attended the deceased from 2 19 62 , 19 to 9 24 67 , 19, and that death occurred at 3:50 M, from causes and on the date stated above.			
22a. SIGNATURE A. L. Mooney		22b. DATE SIGNED 9 25 67	
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY		22d. ADDRESS VA Hospital - Perry Point, Maryland	
23a BURIAL, CREMATION, or other disposition	23b DATE THEREOF SEPT 27, 1967	23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln - Wash D.C.	23d. LOCATION (City or Town) (County) (State) BLADENS BURG, MARYLAND
24 FUNERAL DIRECTOR CHAMBERS FUNERAL HOME - Riverdale, Maryland		25a REC'D BY REG STRAR DATE SEP 27 1967	25b REG STRAR'S SIGNATURE Charles Judge

DEMS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 1/64
25M 1/64

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please detach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

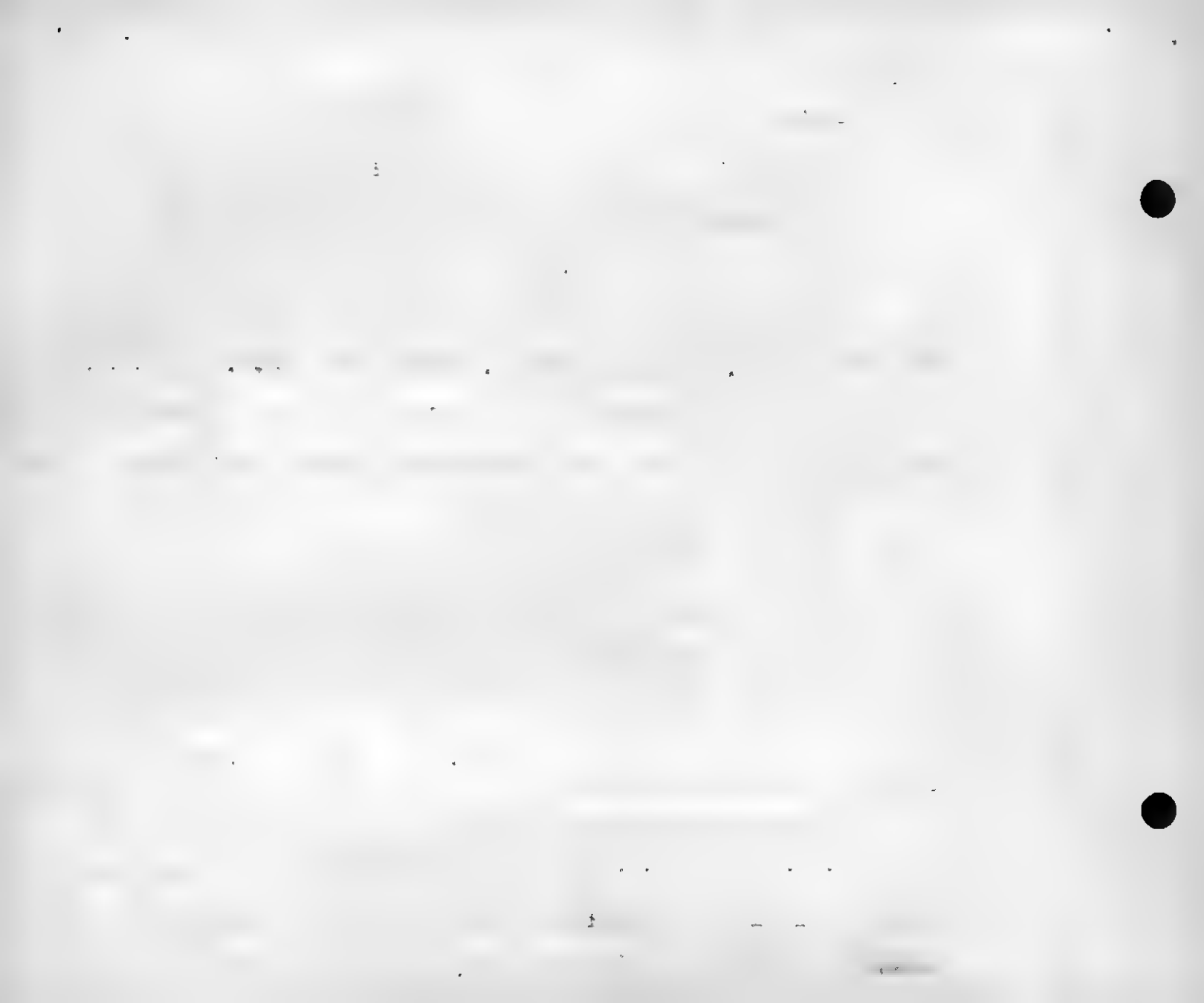
12328

CERTIFICATE OF DEATH

12333

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN lb 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VA Hospital		e. STREET ADDRESS -	
3. NAME OF DECEASED (Type or print) First Alson Middle Paul Last WADDELL		4. DATE OF DEATH Month 9 - Day 25 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-15-96
9. AGE (In years last birthday) yrs. 71		10. IF UNDER 1 YEAR Months 11 Days 10 Hours 10 Min 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter Ret.		10b. KIND OF BUSINESS OR INDUSTRY Construction Co.	
11. BIRTHPLACE (County & State, or foreign country) Grassy Creek, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Waddell (Deceased)		14. MOTHER'S MAIDEN NAME Martha Richardson (Deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 218-03-04-36	
17. INFORMANT VA Hospital Records - Perry Point, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure			
4200 DUE TO (b) Arteriosclerotic heart disease			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
Chronic pulmonary emphysema			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF OTHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from Sept. 25, 1967 to Sept. 25, 1967 , that the deceased died on Sept. 25, 1967 , and that death occurred at 4:00 p.m. from causes and on the date stated above.			
22a. SIGNATURE A. L. Mooney		22b. DATE SIGNED 9-26-67	
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D.		22d. ADDRESS VA Hospital - Perry Point, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-28-1967	
23c. NAME OF CEMETERY OR CREMATORY Conowingo Baptist Cemetery		23d. LOCATION (City or town) (County) (State) Conowingo, Maryland	
24. FUNERAL DIRECTOR TYSON		25a. REC'D BY REGISTRAR SEP 29 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. FUNERAL HOME - Rising Sun, Md.	

MEDICAL CERTIFICATION



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12334

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Cecil MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) b STATE Del. b COUNTY New Castle	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c LENGTH OF STAY IN 1b D.O.A.	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		e STREET ADDRESS 62 Maple Drive	
3 NAME OF DECEASED (Type or print) Wayne David Wallace		4 DATE OF DEATH 9 23 19 67	
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B DATE OF BIRTH 2-13-67	9 AGE (In years last birthday) yrs 7 10
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11 BIRTHPLACE (State or foreign country) Del.	
13. FATHER'S NAME Unk.		14. MOTHER'S MAIDEN NAME Sandra Lee Wallace	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO None	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		17 INFORMANT Sandra L. Wallace, 62 Maple Dr., Newark, Del.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 140 Asphyxia DUE TO (b) Rubber pants over face. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH Unk.
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Rubber baby pants fell over face in crib.	
20c TIME OF INJURY Month, Day, Year 5:50 p.m. 9-23 19 67		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office, etc.) Home		20f (City or town) (County) (State) Newark, New Castle, Del.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John M. Byers, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John M. Byers, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town or county)	
22a BURIAL CREMATION REMOVAL (Specify) Burial		22b DATE THEREOF 9-26-67	
22c NAME OF CEMETERY OR CREMATORY Silverbrook Cemetery		22d LOCATION (City or Town) (County) (State) Wilmington N.C. Dela.	
22e FUNERAL DIRECTOR William J. Narwick		22f ADDRESS Newark, Dela.	
22g RECEIVED BY REGISTRAR		22h REGISTRAR'S SIGNATURE	
DATE SEP 26 1967			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12325

CERTIFICATE OF DEATH

12335

1 PLACE OF DEATH a. COUNTY Cecil MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun Rural	
c. LENGTH OF STAY IN 1b Life		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Melvin Bond White		4 DATE OF DEATH Sept. 6 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 6-20-1910
9. AGE (In years lost birthday) 57 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor Ret. Construction Co.		10b. KIND OF BUSINESS OR INDUSTRY Maryland Cecil Co.	
11 BIRTHPLACE (County & State, or foreign country) U.S.A.		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William W. White		14. MOTHER'S MAIDEN NAME Viola Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 218-05-3066	
17 INFORMANT Mrs. Melvin White		Address Rising Sun, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Aluminum Poisoning DUE TO (b) Poisoning Tobacco DUE TO (c) Poisoning Tobacco		INTERVAL BETWEEN ONSET AND DEATH 39	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6-6 , 1967, to 9-6 , 1967, that (I) (we) last saw the deceased alive on 8-29 , 1967, and that death occurred at 9:30 AM , from causes and on the date stated above.			
22a. SIGNATURE G.H. Richards		22b. DATE SIGNED 9-6-67	
22c. PHYSICIAN'S NAME (Type) G.H. Richards		22d. ADDRESS Port Deposit Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-9-1967	23c. NAME OF CEMETERY OR CREMATORY Hopewell Cem.	23d. LOCATION (City or Town) (County) (State) Port Deposit Cecil Md.
24. FUNERAL DIRECTOR Ernest J. Fuller		25a. REC'D BY SEP 11 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12326

CERTIFICATE OF DEATH

12336

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Pennsylvania b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 22 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Philadelphia	
f. STREET ADDRESS 1185 Morefield Road		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ALBERT F. WIDMANN		4. DATE OF DEATH Month Day Year September 6 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-26-95
9. AGE (In years last birthday) yrs. 72		10. IF UNDER 1 YEAR Months Days Hours Min 72	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Widmann		14. MOTHER'S MAIDEN NAME Mary Kessler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 088-09-4385	
17. INFORMANT VA Hospital Records, Perry Point, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Branchepneumonia, bilateral DUE TO (b) Arteriosclerotic heart disease DUE TO (c) Arteriosclerosis, Generalized Interval between onset and death 7-10 days years			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral arteriosclerosis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from Aug. 15 , 19 67 , to Sept. 6 , 19 67 , and that death occurred at 7:30 M , from causes on and on the date stated above.			
22a. SIGNATURE A. L. Mooney M.D.		22b. DATE SIGNED 9-6-67	
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, M.D.		22d. ADDRESS VAH, Perry Point, Md.	
23a. BURIAL (CREMATION REMOVAL) (Specify) Burial		23b. DATE THEREOF 9-9-67	
23c. NAME OF CEMETERY OR CREMATORY Shoot's Cemetery		23d. LOCATION (City or Town) (County) (State) Dauphin County, Harrisburg, Pa.	
24. FUNERAL DIRECTOR Patterson Funeral Home, Perryville, Md. for Zimmerman Funeral Home, Harrisburg, Pa.		25a. REC'D BY REG. STRAR DATE SEP 11 1967	
25b. REG. STRAR'S SIGNATURE Charles Judge			

Journal of Management Education 30(6)

LEADER OF POLITICAL PARTY, 1940-1941.

214

1524

1997

2000

... ..

515-

DECLASSIFIED : 2019-08-21-17

Journal of Management Inquiry 16(4)

CC BY-SA

1947

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12327

CERTIFICATE OF DEATH

12337

1. PLACE OF DEATH a. COUNTY CECIL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HOLLYWOOD BEACH		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HOLLYWOOD BEACH	
c. LENGTH OF STAY IN b. 18 YRS		d. STREET ADDRESS 071	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ROLAND First H. Middle Wilson Last		4. DATE OF DEATH Month Sept Day 28 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 24, 1901
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months — Days — Hours — Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BELL TELEPHONE		10b. KIND OF BUSINESS OR INDUSTRY PHONE	
11. BIRTHPLACE (County & State, or foreign country) PHILA. PA		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME HARPER WILSON		14. MOTHER'S MAIDEN NAME CATHERINE ROLAND	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 163-01-0747	
17. INFORMANT VIOLET M. WILSON - CHES CITY, MD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — (c) —			INTERVAL BETWEEN ONSET AND DEATH years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bilateral pneumonia Residuals of Previous CVA			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. —	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 17 Sept, 1967 to 28 Sept, 1967 that (I) (we) last saw the deceased alive on 28 Sept 67 , and that death occurred at 7 AM , from causes and on the date stated above.			
22a. SIGNATURE Wallaxe Obenshain		22b. DATE SIGNED 2 Oct 67	
22c. PHYSICIAN'S NAME (Type) Wallaxe Obenshain, MD.		22d. ADDRESS Cecilton, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 10/3/67	23c. NAME OF CEMETERY OR CREMATORY St JOHNS U. B.	23d. LOCATION (City or Town) (County) (State) PARADISE PA
24. FUNERAL DIRECTOR PIPPIN FUNERAL HOME		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 3 1967	

1

15

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
12328 CERTIFICATE OF DEATH 12338									
Reg. Dist. No.									
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton					c. LENGTH OF STAY IN 1b 66 yrs.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital					d. STREET ADDRESS Warrick				
3. NAME OF DECEASED (Type or print) First Middle Last Mary Woolford					4. DATE OF DEATH Month Day Year Sept. 8 19 67				
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 5, 1901		9. AGE (In years last birthday) 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James Wanamaker					14. MOTHER'S MAIDEN NAME Lucy Duker				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. 221-14-3959				
					INFORMANT Address Audrey Knight- Warrick Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus Coronary occlusion with massive anterior infarction 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from 5 Sept 67 to 9 Sept 67, that I last saw the deceased alive on 9 Sept 67, and that death occurred at 3 pm from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Wallace Obenshain Cecilton Md. 12 Sept PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D. Cecilton, Md.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 9/16/67		22c. NAME OF CEMETERY OR CREMATORY Dale Cem.			22d. LOCATION (City, town, or county) (State) Middletown, Del.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Bell					ADDRESS 909 Poplar St.		24a. REC'D BY REGISTRAR SEP 14 1967		24b. REGISTRAR'S SIGNATURE Charles Judge



University of California, Berkeley

Cecil R. Wright

William Brewster